COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

POSTAGE STAMPS REQUEST

DATE: _____

TO: ACCOUNTING DIVISION

FROM: _____
(Facility Name)

COST CENTER CODE: _____

Total number of stamps requested _____ Denomination _____

Total number of stamps requested _____ Denomination _____

DOLLAR VALUE $_____

JUSTIFICATION: _____

_____

REQUESTED BY: _____ TELEPHONE # _____
(Custodian)

APPROVED BY: _____ DATE _____
(Clinic Manager)

(FOR ACCOUNTING DIVISION USE ONLY)

DATE: _____

TO: _____

FROM: ACCOUNTING DIVISION

Total number of stamps issued _____ Denomination _____

Total number of stamps issued _____ Denomination _____

DOLLAR VALUE $_____

JUSTIFICATION: _____

ISSUED BY: _____ RECEIVED BY: _____

TELEPHONE # _____